Agency Name:

Agency Information

Legal name:	
Street Address:	
Mailing Address (if different):	
Agency Telephone:	
Agency website:	
Executive Director Contact Information:	
Name:	
Title:	
Mailing Address:	
Telephone:	
Fax:	
E-mail:	

Funding Summary:	
Program Name:	**Funding Amount Requested:**
1.	$

PERSON AUTHORIZED TO SIGN CONTRACTS (This person must be listed on your Contractor Authorized Signatory Listing Form).	
Name & Title Printed:	

Instructions: Please complete the following information pertaining to your proposed program. *Note: Form must be 'locked' to enable auto fill-in mode. Go to View, Toolbars, Form, click on padlock icon and tab through cells to complete all information.*

Program Contact Information (Contact person for programmatic matters):	
Program Contact Name:	
Program Contact Title:	
Street Address:	
Mailing Address (if different):	
Telephone:	
Fax:	
E-mail:	
Financial Contact Information (Contact person for fiscal matters):	
Financial Contact Name:	
Financial Contact Title:	
Street Address:	
Mailing Address (if different):	
Telephone:	
Fax:	
E-mail:	
Contract Manager (Person responsible for contract):	
Check here if same as Program Contact:	☐
Check here if same as Financial Contact:	☐
Contract Manager Name:	
Contract Manager Title:	
Street Address:	
Mailing Address (if different):	
Telephone:	
Fax:	
E-mail:	

Program Summary:
Please write a summary in the box below, no more than 5 sentences, of your proposed program. When completing this section, be sure to hit 'enter' to begin a new line to avoid formatting issues.

Indicate staffing request and volunteer commitment:	
Full time employment =	hours (e.g. 40; 37.5; 35)
# of direct service FTEs	
# of FTEs requested not providing direct service	
# of volunteer staff FTEs (not required)	

To determine # of FTEs, add the total number of staff hours and divide by full-time hours. For example, 3 staff work 40 hours, 40 hours, and 20 hours respectively. 40 + 40 + 20 = 110.
110/40 = 2.5 = 2.5 FTEs.

Indicate organization type:

☐ Non-profit	☐ Governmental

Check yes or no to answer the following:	**Yes**	**No**
Does your organization self-identify as faith-based?	☐	☐
Does your agency currently have any contracts in place with the Commonwealth of Massachusetts?	☐	☐

Comments [use this only if there is a need to qualify any of your above response(s)]:

Indicate the county(s) in which your funded staff provide services:

☐ Barnstable	☐ Plymouth
☐ Bristol	☐ Worcester
☐ Essex	☐ Norfolk
☐ Suffolk	
☐ Middlesex	☐ All Regions

Contact person designated to address questions regarding this document:

Name:	
Title:	
Telephone	
E-mail:	

Proposed Programing

In the space provided please outline how services would be provided. Be sure to summarize how your respective program will meet the objective "to provide in home Behavioral Health services" (up to 2x per week) to the respective region(s) and client levels identified in the RFR.

Include a in your summary:

- Number of years in operation
  Description of your existing *capacity* to meet the need identified within the RFR for the respective region(s) and client level
- Identify existing contracts with the Commonwealth of Massachusetts - Program level (if any)
- Summarize supervision structure utilized

Please limit response to 2.5 pages.